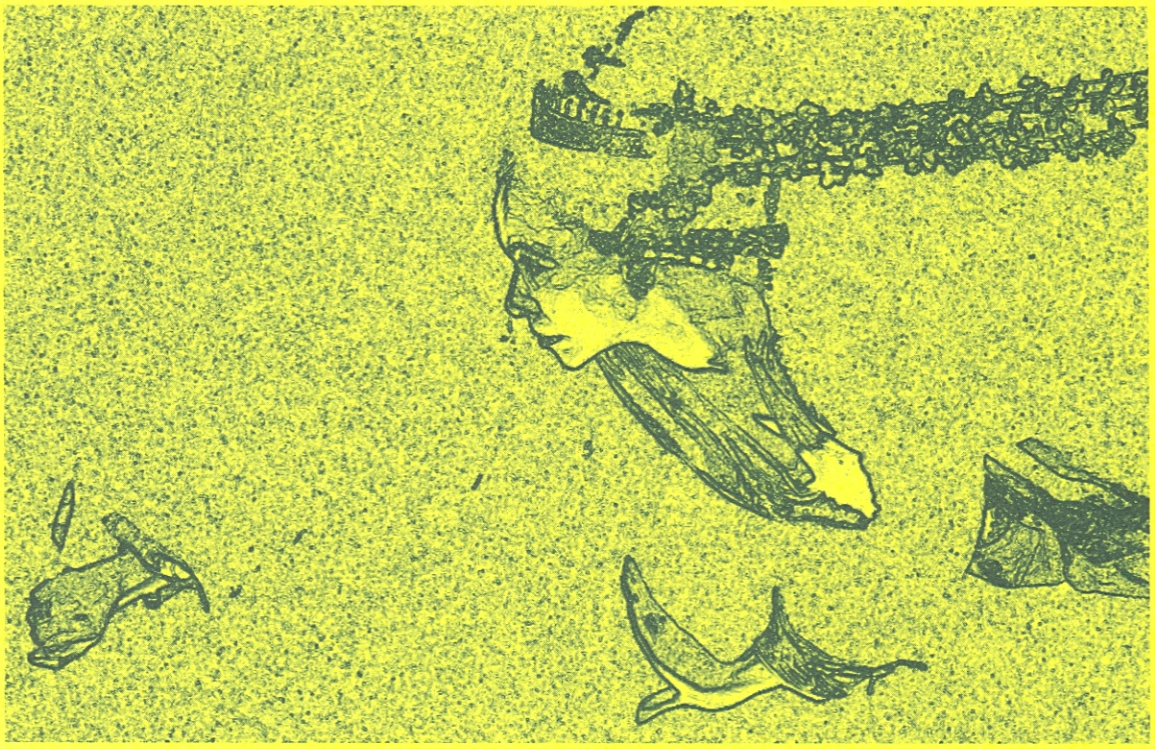
**PART 2**

# Gender and Women's Health



## Ideas for Action

Information Package No.2

Asian-Pacific Resource & Research Centre for Women (ARROW)

# Contents

In this article, the author examines how primary health care (PHC) programmes have failed to address gender inequalities in health. She argues that PHC programmes have in fact, perpetuated the stereotypes of women as mothers and wives. She then goes on to identify gender issues in women's access to health services, before proposing several important elements that need to be dealt with at the various levels—personal, household, community and national—in planning health projects and programmes.

# Gender Issues in Primary Health Care

by T.K. Sundari Ravindran

## The Primary Health Care Approach

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PHC was conceived as comprising of eight essential elements:

- education, concerning prevailing health problems and methods of preventing and controlling them;
- promotion of adequate food supply and nutrition;
- adequate supply of safe water and sanitation;
- maternal and child health [MCH] care, including family planning;
- immunisation against the major infectious diseases;
- prevention and control of locally endemic diseases;
- appropriate treatment of common diseases and injuries;
- provision of essential drugs.

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Despite making significant advances by linking health and development and going beyond medical solutions to health problems, this approach to PHC is largely insensitive to gender issues in health. This is despite the fact that PHC is supposedly concerned with inequities in health. The ways in which the sexual division of labour, and gender-based discrimination influence women's health status is neither addressed nor understood. PHC does not recognise inequities within the household, nor go beyond viewing women as merely mothers and housewives.

Consequently, it confines its vision of women's health needs to the realm of MCH, where the focus is mainly on the child, with the mother seen as a vehicle for child health.

PHC also demands a great deal from women as providers of health care in the household, ignoring their multiple roles and time constraints. The approach focusses on educating mothers, and promoting health interventions at the household-level which add further to women's workload. It takes for granted women's role as carers and health providers, while at the same time not acknowledging their knowledge about health care and healing, but imposing ideas from above.

When PHC projects employ women community health workers, they expect them to do voluntary work, while this is seldom the case when men are employed. Worse still, many messages regarding disease prevention have tended to "blame" women's lack of awareness and ignorance concerning their own, and their children's illnesses.

However, PHC is an important step forward from the earlier, biomedical approach to the solution of health problems. The need is to make the approach to PHC more gender-sensitive, rather than to negate the validity of the PHC approach itself. Addressing gender issues through a PHC approach would mean:

- acknowledging and acting on the premise that the community is not a homogenous group but may be divided along lines of gender, class, race, ethnicity and caste;



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- being aware of how gender roles affect women's health needs and the variations in these across different social strata;
- addressing problems faced by women as providers of health care within the formal health sectors, and as informal carers at home;
- recognising, valuing, and using women's indigenous knowledge and skills in traditional medicine;
- changing the tendency in health education to "blame the victim";
- planning in consultation with women, and respecting women's knowledge of the community's health needs.

## Gender Issues in Access to Health Services

The use of health services may be seen as consisting of three main components:

- **Decision:** recognising the need to seek health care, and deciding to seek care.
- **Contact:** making contact with a source of health services delivery.
- **Care:** obtaining adequate and appropriate care.

Women's use of appropriate health services is constrained by barriers acting at each of these levels: first, in deciding that it is necessary to seek help for the health problem. Decision-making is affected by a woman's power and self-esteem, as well as her level of knowledge. The woman may deny even to herself that a problem exists. Or she may not recognise the condition as abnormal. Even when a woman recognises that a problem exists, in the event of it being a gynaecological problem, she may be too shy or embarrassed to seek outside help, and may prefer to tackle it at home, through home remedies. Even if a woman wants to seek medical help, she may be unable to do so since the decision to do so does not rest with her, but with her husband or elders in the family. She may be expected to cope by herself with any health problems she has, unless they are very serious. Because of this, women may hesitate to complain of ill health.

The second point at which women's ability to obtain health care is constrained is in reaching a place of service delivery. Having decided to seek health care, a woman has now to overcome a series of other obstacles, such as distance from the health centre, and lack of time and money. There may be no one to look after her children; the timings of the health centre, and the long queues, may mean losing a day's work and wages. In many cultures, a woman may only travel if accompanied by a male family member, and therefore, his convenience and interest become a determining factor.

Third, when she reaches a health facility after overcoming these barriers, a woman may still not receive appropriate or adequate health care. First of all, the health centre may not be in operation, because the doctor and nursing staff do not come regularly. If there are no feniale health staff in attendance, women may not express all their concerns to the male health staff. The services of the health facility may be limited to a narrow spectrum, with only MCH care aimed specifically at women. Reproductive health problems are many and varied, and women may not find either the facilities for screening, or personnel with appropriate skills. More often than not, women patients may be sent back after superficial treatment of their symptoms. Lastly, even if a woman begins treatment, the opportunity cost of follow-up may be too high for her to continue with, and complete, the treatment.

Women's access to health care is thus a complex issue, going far beyond merely putting a health facility in place. The barriers to women receiving health care are caused by women's status at individual and community-level, as well as by national policies. These individual and community-level barriers are composed of two elements: problems women face as a result of being poor, illiterate and powerless, due to factors including class, race or ethnicity; and problems arising from the fact that they are women in a patriarchal society which has inherent gender-based discrimination.

Ravindran, T.K. Sundari. 1995. "Gender issues in primary health care".

## Integrating Gender Issues into Health Care

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Some important issues to be taken note of, when planning health projects and programmes are as follows:

- Women's health needs are different from those of men, not only because they are biologically different, but also because their social realities are different; the health risks they encounter are different, as also their health-seeking behaviour.
- Women are not only mothers and wives, but have multiple roles, as producers, reproducers and as members of patriarchal communities. This renders them more vulnerable to health risks than men. The disadvantages suffered in each role complicate any existing health condition. It is therefore not sufficient to provide the same kind of health care to both sexes even for health problems common to both, such as communicable diseases. Programmes have to be designed with an awareness of how the same health problem may affect women differently.

  Women's health needs extend throughout their life cycle, and beyond their reproductive roles. In addition to problems related to reproduction, women are also exposed to all the health problems that affect men. They therefore need far more than maternal health care. Surprisingly, even reproductive health problems have received very little attention in countries and programmes, including Oxfam-supported programmes. There is a need for more research and better understanding of reproductive health issues so that these may be better addressed in future.

## Working at Different Levels

### Micro-level

At the micro-level, interventions have to go beyond treating the household as the beneficiary, and start paying attention to intra-household inequities in resource allocation. Micro-level work aiming to help women to improve their health cannot confine itself merely to neatly packaged interventions addressing one or two "health problems", since the issue is one of powerlessness to take care of oneself. Powerlessness both contributes to women becoming ill and makes it difficult for them to seek health care. A starting point to address women's lack of power would be to create opportunities for women to challenge their oppression and change their situation, both as women and as members of a marginalised group or community.

Recently, micro-level interventions have begun to grapple with issues of sexuality: its construction, and the unequal power relations embodied in the way sexuality is manifested in men and women. Addressing sexuality is central to any work on women's reproductive health, since nearly all reproductive health problems are related to the construction of male and female sexual identities and roles, and to male control over female sexuality.

Development workers sometimes have difficulties in addressing the issue of sexuality. One of the concerns of many NGO workers is that sexuality is private and personal, and its link to development is not clear to them. In addition, many workers who are sensitive to gender issues in their work are less so in their personal lives. The problem of linking development and sexuality is that it brings gender issues of male power and female subordination "closer to home", challenging the way of life of many development workers and health providers.

Many health groups do not feel that their work includes issues related to sexuality and reproductive health. This may be because they have not addressed the issue of sexuality with members of the communities with which they work.

### Macro-level

At the level of national and international policy formulation and advocacy, work is needed to

Ravindran, T.K. Sundari. 1995. "Gender issues in primary health care".

influence development policies to be gender-sensitive, and especially to ensure that they do not lead to further deterioration of women's situation. Economic and political decision-making has practical effects on women's and men's well-being, which may lead to ill health. Policies that negatively affect the health and well-being of people, such as those affecting food security, employment and wages, and social services, have to be challenged.

**Rauindran, T.K. Sundati. 1995.** "Gender issues in primary health care", in *Gender Issues in Health Projects and Programmes. Report from AGRA East Meeting, 15–19 November 1993, The Philippines. Oxfam Discussion Paper 5.* pp. 20–23.

In this paper, some of the major psycho-social factors which determine the various conditions of women's health in Nepal are highlighted. The identified determinants are categorised into four factors: patriarchal-structured gender relations and their effects on girls and women through their life cycles; socialisation patterns; impacts of heavy workload on health and occupation-related hazards; traditional attitudes, customs and superstitions. This is an example of a gender analysis of women's health being applied at a country level.

# Major Psycho-Social Determinants of Women's Health in Nepal: A Gender Perspective

by Jyoti Tuladhar

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## Social Structure and Value System Engendered by Patriarchy

Nepalese society is predominantly patriarchal, patrilineal and patrilocal (with the exception of certain ethnic communities of the Tibeto-Burman group). Three fundamental features characterising patriarchy are patrilineal inheritance system, control over women's sexuality and body, and restriction over women's mobility. Women are given a subordinate position at all levels: economic, control and power over body and movement, and power of descent. Thus, at the most intrinsically basic level, women are reduced to a position of secondary importance. All forms of discrimination and inequity ensue from this. Therefore, patriarchy operationalised through the family system, needs to be carefully analysed, understood and addressed if social injustice that prevails against women is to be countered.

It is this basic patriarchal predominance which affects women's health negatively in both direct and indirect manners. If we examine a woman's life through the various phases of her life cycle, it becomes crystal clear as to how this societal structure and the concomitant value system have affected women's health, right from conception to old age.

. . . some major issues concerning the health of women are:

- Women have very little or no reproductive rights, either to have the desired number of children, or to select marriage partners, or choose when to get married or not, or adopt family planning methods without the husband's consent.
- Women's recognition and status in the family comes through the production of sons. Infertile women or women only with daughters are doomed. Therefore, women continue giving birth until they have at least one mandatory son and more if possible.
- A woman has no security if her fertility system fails. She has no access to her own independent resources, no property rights in her natal home, and her status in her husband's home may be jeopardised in any event of desertion or abandonment by her husband.
- The situation is made more acute by the fact that according to the *MULUKI* AIN of Nepal (Law of the Land, Clause 9), on the basis of the following six conditions, men

are permitted to remarry, leaving women deprived and destitute:

- if the woman is mentally ill with no possibility of cure;
- if she has an infectious or incurable venereal disease;
- if she is an invalid and cannot move;
- if she is blind in both the eyes;
- if she has borne no child after ten years of marriage;
- if she is living separately, taking her share of ANSA.

- Since women derive their identity and social worth from the notion of motherhood rather than womanhood, medical treatment also gives priniary attention to health care related to childbearing and family-rearing. Women's non-maternity related health needs are thus overlooked. Single women's gynaecological problems are also not given any place in the health care system.

## Socialisation Pattern

The entire socialisation pattern in the Nepalese society is such that the young boys are prepared for the world of productive work and decision-making while the girls are trained to be effective housewives, mothers and service providers. From a very young age, it is instilled into the girls' minds that their duty lies in providing services to their family—domestic chores, sibling care, and assistance to the mother in household responsibilities—to prepare her for the world of care-taking of future generations.

Self-denial, putting others before oneself, self-effacement, gentleness, sacrifice, soft-spokenness and other "feminine" qualities are encouraged in her upbringing. Decision-making, strength of expression, articulateness, opinion formation, thinking of one's own needs and interests, future career planning, etc., are not qualities which are facilitated to develop in her socialisation process. Furthermore, she is for the most part confined to an "inside world", not permitted to interact with the "outside world" of information, knowledge and various forms of resources.

The cumulative psychological effect of this kind of socialisation process becomes evident later in her treatment of her own body. Many young girls have been known to have become hysteria patients due to psychological repression and sexual ignorance.

How the socialisation process as induced by traditional and customs affect the mental attitudes of young women can be clearly illustrated by the traditional attitude towards menstruation, for example. Menstrual blood is looked upon as impure and the onset of menarche, even among the educated, is viewed with alarm and a restrictive negative outlook which frightens the young girls. As a result, they look on it as a curse and as a sign for something they have done wrong. The rituals performed at the beginning of the first menstruation and the instructions to abstain from religious and other daily activities during the menstruation period further confirm this fear and instil in them a sense of undergoing an abnormal condition. Instead, family should have extended support and a positive environment at the first "unusual experience" of young girls, explaining to them that this is a normal body function upon which the creation of the whole human race depends.

Open and frank discussions between daughters, mothers, and seniors regarding menstruation, sex and pregnancy are not the normal rule. Girls learn the facts of life from their peers and are embarrassed to talk about their problems with older women. Very often this leads to unnecessary physical and psychological health problems later, for which there are no early provisions in the medical system. Adolescent girls have no access to health/sex education or medical services to deal with their problems.

"Chastity" protection and preservation of female sexuality is highly valued in the socialisation patterns in the mainstream Nepali culture. Chastity is a complex concept from which emerge various constraints and restrictions placed on women in the socialisation process—restricted mobility, need for social acceptability and prestige *izzat,* need for male protection, high value attached

Tuladhar, Jyoti. 1994. "Major psycho-social determinants of women's health in Nepal".

to gentleness, submissiveness, and conservative outlook, and lack of encouragement for initiative and risk-taking. These values imbibed through years and years of socialisation in the male and female psyche in the Nepalese society constitute the strongest psycho-social barrier to the strengthening of women's status.

Furthermore, "the son preference and daughters neglect" syndrome has an extensive and deep-rooted physical and mental impact on the daughters who are discriminated against. It adversely affects their self-esteem and socialises them into putting themselves last when the distribution of food and other household resources takes place. This habit becomes so entrenched that even when opportunities are available, they may not look after themselves well. For example, in many rural areas, women are found not to take care of themselves during pregnancy, following traditional dietary taboos even when they are aware that these can have strong negative effects on their own health and their own foetus.

## Gender Division of labour and Heavy Workload for Women

Gender division of labour leading to gender stereotyping of jobs is a traditional feature of the Nepalese society. Women's working hours are very long and strenuous. In the rural setting, household chores such as cooking and washing, fetching of water and firewood combined with agriculture-related activities engage them for more than ten to 12 hours. In the urban setting, working women face double responsibilities of household work as well as professional demands. A high-level of stress and irritation is expressed by many of these women trying to be super women. While rural women complain of backaches, lung infection, injuries due to falls, etc., urban employed women suffer from ulcers, stress, headaches and fatigue. Trying to cope with and excel in both the inside and the outside worlds, often leads to psychological trauma.

## Traditions, Customs and Superstition

In Nepal, fatalism is firmly rooted (Bista, 1992). There is a pervasive belief that one has no personal control over one's life circumstances, and if the course of events is already determined, it makes little sense to try to independently influence their outcome. Fatalism is connected with various forms of dependencies, responsibility is displaced to the outside, to the supernatural. There exists a deep core of fatalistic beliefs among women, especially among the rural uneducated women. Perhaps, they derive psychological relief and peace from leaving everything to fate, since life seems so very much beyond their control.

In addition, lack of education, information and knowledge about their own bodies complicate the problems. On one hand, there is a storehouse of indigenous knowledge and traditional healing skills among the women which should be preserved and encouraged; while on the other, they are prone to deeply entrenched superstitions and traditional customs which cause severe damage to their health. Dietary taboos on food, inadequate protection during pregnancy, for instance, can cause serious damage to their health. A sense of alienation and isolation is imparted through mandatory segregation during menstruation periods and delivery times. It is argued that this allows women time for rest, which may be true to some extent, but the psychological communication is that they are segregated because it is an impure, untouchable state. Apart from actual physical discomfort, this is psychologically taxing for women, and gives them a sense of being "religiously" and "culturally" unclean and a source of pollution. There is a sense of shame attached to this event.

The areas of women's intense physical and psychological suffering are often kept concealed from public attention: domestic violence and abuse, and sexual harassment/ rape. Nearly 70 per cent of rape cases of women and minors go unreported. Violence

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within the house is considered a personal matter, and wife beatings, both physical and psychological damage, are justified by religious and traditional beliefs. "A man has a right to *tie* and beat his wife *with* a bamboo stick if she does not listen to him" *(Matsya* Purana). Subsequent health damage is inevitable. The commoditisation of women's body and man's ownership and control over it, rob women psychologically—robbing them of their self-esteem, self-confidence, initiative and decision-making ability.

## Conclusion

To sum up, the psycho-social factors act as very powerful determinants of women's health. Therefore, intensive efforts are essential to do the following:

- raise the self-image and self-perception of women through knowledge of the self;
- sensitise men on the critical health issues facing women; empower women through leadership, confidence-building, skill development and management and capacity-building;
- communicate to the policy-makers the inadequacy of conceiving women only in their reproductive functions; viewing women in a more holistic sense as individuals could cumulatively lead to speedier success in the population control measures that the country so desperately needs;
- work towards the elimination of all forms of violence against women—physical and psychological;
- incorporate more women in decision-making positions in the health sector at all levels;
- extend special health care provisions for non-maternity related needs of women of all ages;
- work towards affecting attitudinal changes towards women's health, at home and at the decision-making, policy-making and implementation levels;
- public media need to be mobilised to present women in non-mother-wife roles; even with regard to fertility control measures, women need to be treated not as instruments or objects, but as subjects with control over their own reproductive rights;
- indigenous health knowledge of women in domestic treatment through herbs and spices should be promoted wherever appropriate.

**Tuladhar, Jyoti. 1994.** "Major psycho-social determinants of women's health in Nepal: a gender perspective" in Uprety, **Aruna** [et **al.**]. ***Report of the Gender and Women's Health Workshop, Nepal, 7–9 July 1994.*** Kathmandu: RECPHEC. pp. 40–50.

This article discusses two related areas or sections concerning integrating gender and health issues into grassroots-level projects. The first section outlines a framework for a gender-sensitive health intervention programme. The second section provides some insight for funding agencies on possible constraints when working together with grassroots NGOs to integrate gender issues in health projects or programmes. This article concludes with a list of 11 questions for assessing the gender-sensitivity of health programmes.

# Addressing Gender and Health Issues in NGO Programmes

by T.K. Sundari Ravindran

## Working at the Grassroots

Working at the grassroots-level on gender and health issues essentially consists of attempting to equip women to meet their practical needs strategically; that is, in a manner which will allow them to increase their status in the community, as well as benefit them on a practical level in their day-today lives.

All work in this direction has to embrace some basic principles. Gender-sensitive health interventions should:

- start from women's own assessment of their needs;
- build on women's knowledge and skills and further enhance these;
- not in any way accentuate gender-based discrimination or dependency, but actively seek to redress these;
- contribute to women's ability to organise as a group, take leadership roles, articulate their demands, and seek both macro-level changes in policies and programmes, and changes in the way these are translated into action at the community level.

The effective grassroots work on gender and health which has been undertaken, typically begins with awareness-raising, to help women understand and exercise greater control over their bodies, and to enhance their self-confidence and self-image. The processes adopted are participatory. Awareness-raising usually begins by creating time and opportunity for women to reflect on the realities of their lives, articulate their feelings about their experiences as women, and move on to question why their lives are the way they are, and if they could actually be different.

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When dealing with health issues, the focus is on revalidating what women already know, and at the same time, identifying gaps in knowledge. This is followed by acquisition of specific knowledge on the health issues identified. Medical knowledge is "demystified", and made available to women, so that they have better understanding of their health problems, and are able to negotiate more effectively for appropriate health care, with service providers.

Changing attitudes and health-seeking behaviour is a more difficult task than building knowledge and skills. The overall purpose is to encourage women to initiate self-treatment or seek medical help when ill, to actively seek ante-natal and delivery care, and more importantly, to feel entitled to good health and care. It calls for an integrated process of making women more assertive and aware of their capabilities, as well as equipping them with leadership skills, such as articulating their thoughts clearly, speaking in public, facing up to authorities, and so on.

Since good health is an essential part of development, demanding the right to health leads on to demanding that basic needs of the

community be met: that wages are high enough to ensure food security, that there is guarantee of employment, and so on. It also involves fighting against all forms of inequities, since these deny people good health and well-being. Working on gender issues in health is a logical component of any development programme, and not only of health care programmes. Such work is also part of any consciousness-raising programme seeking to organise workers and marginalised groups, to demand their rights.

What difference would a gender-sensitive approach to health and health care make to the nature of specific interventions? Given below are some illustrative examples. First, let us take the case of improving the nutritional status of women and children. A gender-sensitive approach would not start with the assumption that the central problem is women's lack of knowledge about the nutritional value of foods. It would begin with an open dialogue with the women on what the problems are; these may be problems related to non-availability of foodstuff at affordable prices, lack of fuel, lack of time to make nutritious but elaborate preparations, or lack of energy due to chronic fatigue. Intervention may then focus on organising women and men to demand higher wages, or on making food processing easier, or making fuel readily available, or setting up community kitchens, instead of giving "nutrition-talks" to women. Other approaches include alleviating women's work load, and thus reducing the energy they need to expend, while at the same time improving food intake.

Gender-sensitive approaches to family planning services would dramatically alter their content and focus. Instead of assuming that women's ignorance causes them to breed without control, family planning services would become a means of enabling women to regulate their fertility. Fertility awareness would form the core of the programme, and women would be given information on and access to a wide range of methods. Family planning services would be integrated with services for other reproductive health problems, and backed up with adequate follow-up as well as abortion services.

At the grassroots-level, raising of gender-awareness, training and skill-development for self-help in health, leadership training, provision of specific services and organising women, are thus, some of the important activities that would form part of a health programme which has a gender perspective.

## Issues for Funding Agencies Working with Partners

How would a donor agency go about raising gender issues in health with its partners? We shall start from the premise that most project partners would be willing to address gender issues, but are faced with genuine constraints. It is important for the field staff of donor agencies to carry out an analysis of these constraints, and the potential for change within partner agencies, and to work out systematic strategies for addressing these in ways suited to the requirements of different partners.

However, before we begin to examine the potential for change in partners' organisations, we have to look at our own organisations as well. Strengthening the capabilities and commitment of the country teams of donor agencies would .therefore be the starting point for such an exercise. Questions that field offices may ask themselves in this respect are:

- Is the NGO gender-aware, and committed to gender and development work?
- Do decision-makers in the NGO office provide support to work on gender issues?
- Is there a lead person in the team, or is work on gender issues viewed as everyone's responsibility? Do men take up gender issues?
- Is the style of work in the office conducive to "empowerment" of women in the office, and women's leadership?

When assessing the potential for change in a partner organisation, the factors to be taken into account include any constraints on, and resistance to addressing gender issues; the reasons why these constraints or resistance

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exist; and any opportunities for addressing gender issues within and outside partners' organisations. Any action taken by the donor agencies to address the resistance should be assessed, and if there has been any follow-up to this. Finally, the implications for programme and resource requirements should be noted.

**Reasons for resistance and constraints**

There are many genuine constraints that partners may face in introducing gender issues in health programmes; there may also be resistance to the idea of "engendering" health for a variety of reasons. Constraints include having a small number of staff who already have a great deal to do, so that adding on one more responsibility may be difficult. Even when there are staff available, there may be some reluctance to take up the issue, because personnel do not understand the concepts or lack the skills required. In particular, finding women with the required qualifications and leadership skills may be difficult, because the nature of jobs in NGOs is usually demanding, do not assure job security, and is not desk-based.

At times, the reasons why gender issues are not taken up have to do more with the organisation's structure and style of functioning than with either ideological differences or practical difficulties. It may be that the organisation does not have a clear direction or sustained strategy, and supports projects in an *ad hoc* manner. It may have a top-down structure, with the management taking all the decisions, leaving other staff with a very low morale, and without initiative or willingness to bring about changes. Alternatively, workers with a gender perspective may not have the authority to iniplement changes.

However, it may be easier to address such problems than to find solutions to constraints and resistance arising from ideological differences. NGOs that are dominated by male staff in decision-making positions who are gender-blind may dismiss the entire notion of looking at gender issues as not important. Women NGOs which are driven by a welfarist approach and are not aware of, or sympathetic to gender analysis may claim that gender issues are being dealt with, merely because the NGO works with women. Working for "women's health" is not the same as addressing gender issues in health. The first limits itself to meeting women's practical needs alone, while the second does so in a way that would empower women and address gender-based inequalities.

Yet another source of ideological resistance is from those who believe that inequality caused by class is the basic injustice to be addressed, and that dealing with gender issues could cause divisions and disunity within disadvantaged classes. For others, the resistance is based on accusations of cultural imperialism: "gender" is seen as a fad brought in by funding agencies, and promoted by those influenced by "Western" feminism. There is refusal to recognise both its relevance for developing countries, and the indigenous resistance to male domination which can be found among women at all levels and in all regions.

## Questions for Assessing the Gender Sensitivity of Health Projects[1]

Given below are questions developed for assessing the gender sensitivity of health programmes, which may prove useful for initiating the process of "engendering" health programmes:

What are women's gender-specific health needs in the programme area? What attempt has been made to gain a detailed knowledge of those needs?

- How far do girls receive differential treatment in the project area? How does the project address these issues?

What are the existing constraints on women's time? Does the project reduce women's workload? Does the project load all the responsibility for improved health on women rather than also involving men?

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- Has the project understood the informal local methods used by women (and men) to safeguard physical and mental well-being?
- Is the project clear that women are not a homogenous group, but are divided along class, caste, religious, ethnic lines? Is it clear that the project will benefit poorer, more rnarginalised women?
- Can women in practice make productive use of health facilities, and services, taking into account their workload, daily, and seasonal peaks in activities, financial resources, and lack of mobility and decision-making power? How does the project address these constraints?
- What kind of quality of care is provided by the health services?
- Will the project increase women's involvement in decision-making within their households and wider community?
- Will it increase women's ability to act collectively, and organise within the community?
- Will it improve women's access to, and control over services and infrastructural facilities?
- What impact will the project have on the relationships between women and men?

[1] Source: **Mosse, Julia Cleves.** 1993. Gender and Health: Comments Arising from NGO Proposals and Reports, [Paper Prepared *for]* the *JFS/NGO* Workshop on Gender and Development, July 1993.

**Rauindtan, T.K. Sundari. 1995.** "Addressing gender and health issues in **NGO** programmes", in *Gender Issues in Health Projects and Programmes. Report from AGRA East Meeting, 15–19 November 1993, The Philippines. Orfam Discussion Paper 5. pp. 24–27*

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The excerpt is taken from selected sections of a full report that records the findings of a project exploring the needs of women of non-English Speaking Background (NESB) in the North East Region of Australia, following their discharge from in-patient psychiatric care. The project was conducted in response to concerns expressed by local agencies that women of NESB with psychiatric disabilities, were not able to access community support services. This was in the light of the new directions of psychiatric service policies which define a broader role for community support services in the care of people with psychiatric disabilities. The report highlights gender factors impacting NESB women's mental health. Other factors like working in poorly paid and monotonous jobs, stresses associated with migration experience (social isolation), cultural conflict and trauma prior to migration are also discussed in the full report. This excerpt concludes by putting forward a list of the needs of NESB women following their discharge and the components of a good service model.

# Community Support for Women of Non-English Speaking Background with Psychiatric Disabilities: Strategies to Improve Access to Services in the North East Region of Australia

by North East Women's Health Service Inc.

## Women of NESB and Mental Health

This project was undertaken in the belief that there are significant differences associated with both their gender and their status as non-English speaking migrants that not only contribute to NESB[1] women's different patterns and rates of mental illness, but demand special attention in service delivery. These issues have been explored at length in a number of reports and expert inquiries [9] and are summarised briefly below.

### The incidence of mental illness among women of NESB

Women report higher rates of mental illness than do men [10]; rates are higher for people of NESB than of ESB [English Speaking Background] [11] and women of NESB report higher rates than their Australian-born counterparts [12]. The higher rates of mental illness among immigrant women are not due to factors present prior to migration. Indeed, women of NESB have remarkably good health upon their arrival. However, their health status deteriorates with residence in Australia [13].

### Contributing factors

While there is no consensus among health professionals about the causes of mental illness, a growing body of evidence suggests that stresses in people's environment may either predispose them to mental illness or exacerbate an existing condition. Despite improvements in the status of women in the last 30 years, women are still subject to a relatively high degree of stress. For example, they are more likely than are men to be poor, to be the victims of sexual and domestic violence, to have bad working conditions and to work the "double day" of paid work outside

the home and unpaid work within it. On many of these criteria, women of NESB are doubly disadvantaged [14]. . . .

## The influence of gender on the mental healfh of NESB women

In addition, women of NESB share with their Australian-born counterparts other influences on their mental health. These include:

- **Vulnerability to sexual assault and violence in the family**
  Thirty-eight per cent of girls (compared with nine per cent of boys) are subject to sexual abuse before they turn 18; one in ten adult women will be raped at some time in their lives and family violence occurs in one in every three Australian homes [25]. Research has demonstrated that women who have been subject to physical and sexual abuse, particularly within the family, are over-represented among those with psychiatric disabilities [26].

  While there is no evidence to suggest that domestic violence is more common in families of NESB, the consequences may be worse for NESB women given the degree of social isolation they experience, their higher rates of poverty and the problems they may encounter in accessing helping services.

- **The ferninisation of poverty**
  This is brought about by a combination of factors including women's lower average weekly earnings, women's greater dependence on pensions and benefits, the ageing of the female population, the high proportion of women working part-time and the growing number of sole-parent families, 90 per cent of whom are headed by women. Sole-parent families are more likely than couple families to be in receipt of a pension or benefit and their rates of poverty are some four times higher [27]. There is a link between women's socioeconomic status and rnental illness [28] and sole-parents suffer particularly high rates of mental illness [29].

  Poverty is a particular concern of women of NESB in the early resettlement period . . . [30].

- ***Women*** **as carers of children and aged and disabled relatives**
  Women assume the major responsibility for the home-based care of aged and disabled relatives [31]. Studies indicate that people with a caring responsibility suffer poorer mental health than those without. This is thought to be due to the chronic exhaustion experienced by many carers, their social isolation and the financial difficulties that may arise owing to the constraints on their employment outside of the home [32]. Women of NESB are over-represented among carers. Further, studies suggest that carers of NESB experience a greater degree of isolation. This is due to the difficulties they may experience in accessing community supports and their limited access to the economic resources required to reduce the impact of social isolation (e.g., vehicle ownership) [33].

- **Women's socialisation**
  The traditional female characteristics of dependence, passivity and submission often fail to equip women to survive in a world where masculine traits such as aggression, decisiveness and ambition dominate. Women's traditional characteristics and roles are also frequently devalued in our society. It is difficult for women to step outside of these stereotyped characteristics while at the same time maintaining social acceptance. A number of writers attribute poor mental health among many women to this "catch 22" situation in which they find themselves [34]. Studies suggest that this may be reinforced by mental health professionals who hold very stereotyped views of appropriate behaviour for men and women [35].

- **The shaping of women**
  The pressure on women to be thin has been identified as a significant causal factor in a range of mental health problems in women from poor self-esteem to more serious eating disorders such as anorexia and bulimia nervosa. Women are 90 per cent of the sufferers of anorexia and bulimia nervosa [36].

- **Women's role in the family**
  A body of research and theory locates the origins of much of women's mental illness in their traditional role in the family [37]. This role can be socially isolating, often places women in a position of emotional, physical and economic dependence on men and requires them to subvert their own needs to meet those of others. It is argued that while this role may meet the needs of other family members, women often fulfil it at the expense of their own mental health. This is illustrated by gender differences in the rates of mental illness among married and unmarried men and women. Poor mental health is reported less frequently by married men than their single counterparts. Indeed married men report lower rates of poor mental health than any other group, suggesting that married life is good for men's mental well-being. The same, however cannot be said for women; those who are married are more likely to have poor mental health than those who are single and childless [38].

- **The double day**
  In the last three decades, there has been some relaxation in women's roles, enabling women to play a broader role in the work-force and in public life. However, this has not been accompanied by a parallel reduction in women's domestic responsibilities. The contemporary woman now faces the burden and stresses of the "double day" of paid work outside the home and unpaid work within it. On average, women do 70 per cent of the unpaid work in Australian households. The unpaid work undertaken by men remains relatively constant regardless of the number of hours their partners work in paid work. Women do no less work in the home now than they did in 1974 when their work-force participation rates were significantly lower [39]. The physical and emotional demands of balancing these dual responsibilities have been cited as a contributing factor in poor mental health experienced by some women [40]. These may be of particular concern for women of NESB who may be less likely to have access to community and family supports to assist them in coping with competing demands (e.g. child care) [41]. Women of NESB are also more likely to be working in jobs that are physically and mentally taxing . . . [42].

- **Mental health issues associated with reproduction, biology and sexuality**
  There are a number of issues associated with women's reproduction, biology and sexuality that may be sources of stress for them. These include post-natal depression and psychosis, problems associated with menstruation and menopause and events related to reproduction such as infertility, abortion, miscarriage and still birth [43].

## The Needs of Women upon Their Discharge from In-patient Psychiatric Care

The project identifies that women have a number of needs following their discharge including:

- supportive and informed family, friends and community networks;
- sound discharge planning;
- access to a range of services. This recognises the complexity of women's needs;
- an emphasis on practical support and assertive outreach. This recognises that

North East Women's Health Inc. 1994. "Community support for women of NESB".

mental illness has an effect on women's capacity to use services and to undertake tasks associated with daily living;
- effective co-ordination of services;
- services with expertise in gender, ethnic and mental health Issues;
- culturally and linguistically relevant services;
- choice of gender of service provider;
- "women only" programmes and services.

## The Significant Findings of the Project

### The components of an ideal service model

The findings of this project suggest that women require access to service models that:

- recognise that the family and community—where these exist and where they are a positive force—are a critical source of support in the lives of women;
- view rehabilitation as a two-way process, recognising that women need to learn in the community and the community needs to learn about people with psychiatric disabilities;
- adopt assertive outreach strategies for women with severe psychiatric disabilities;
- place an emphasis on the provision of support for "day-to-day" matters in women's lives, recognising that for many women, a psychiatric disability can be as disabling as a physical ailment;
- see women not only in terms of their mental illness but as individuals with a range of needs, including those for social and recreational activities, general medical care, counselling, housing, employment and income support;
- incorporate specific mechanisms to ensure that the needs of the individual woman are advocated within the service network and that her care is effectively co-ordinated;
- promote collaboration between mainstream health services, specialist psychiatric services, women's health services and ethnic health services and workers;
- recognise that, to achieve positive outcomes for women of NESB, agency time, resources and space must be allocated to meet their specific needs;
- mandate the use of professional interpreters;
- maintain an awareness of and respond sensitively to cultural and gender issues and their impact on women's mental health and their capacity to access services;
- offer, wherever possible, the choice of a service provider who is a woman and who is able to speak the language and understand the culture of the service user;
- incorporate measures to ensure that women have a say in the way in which the service is planned and delivered.

[1] The term non-English Speaking Background refers to all people born overseas in a non-English speaking country, people born in Australia with at least one parent born in a non-English speaking country and people born in Australia who have a strong affiliation to a cultural or linguistic heritage that is not Anglo-Celtic, excluding Australian Aborigines.

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**North East Women's Health Service Inc. 1994.** ***Community Support for Women of Non-English Speaking Background with Psychiatric Disabilities: Strategies to Improve Access to Services in the North East Region.*** **Victoria:** North East **Women's Health Service Inc. 86p.**

This article highlights neglected issues of gender differences in health in developing countries, particularly in the areas of research, and health programmes and policies. As such, there is a dearth of information, especially of an empirical nature, on gender inequalities in the development of health and contraceptive technology, a lack of gender sensitivity in the provision of health services, and gender inequalities in health policies. The article also provides a framework to assess quality of care in health services for women, which includes looking at patient-client communication, interpersonal relations between clients and health providers, and provision of appropriate information from health providers for follow-up.

# Uncharted Ground: Gender Inequalities in Health in the Third World

by Carol Vlassoff

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## Conditions and Diseases Where Gender Research is Needed

Research on women's health in developing countries has been concerned mainly with pregnancy and reproductive health, motivated by anxiety among development agencies and many national governments over rapid population increase and the need to curtail high birth rates. Demographic research on the fertility behaviour of couples in developing countries, as well as on infant and maternal mortality over the past several decades, has been driven largely by a preoccupation with population control, rather than by concern with women's health as a good in itself. It is only in the last decade that the term "reproductive health" began to be used, taking into account broader aspects of women's health than those related to pregnancy and childbirth alone. These broader aspects include abortion, reproductive tract infections, sexually transmitted diseases and to some extent, anaemia and nutrition. Still, concern with women's health, and information about it, has focussed almost entirely on their reproductive roles.

While reproduction and associated morbidities are undoubtedly of central importance to women world-wide, other areas of health are also salient to them. However, because so little research exists on other health issues [13], we are unable to quantify the burden of disease with respect to women or to suggest interventions to address their health concerns [14]. . . . Some diseases, such as tuberculosis, lymphatic filariasis [disease caused by the presence of threadlike parasitic worms in the lymph vessels] and leprosy, are likely to have particularly adverse consequences for women because of their effects on physical appearance, and the social stigma associated with them. Similarly, the health consequences of violence and substance abuse are under-estimated because of social stigma, women's subordinate social roles and fear of the consequences of revealing these conditions. Other health problems, such as respiratory diseases and back pain, often affect women more than men because women's domestic tasks, including cooking over smoky fires in unventilated kitchens, and lifting and carrying wood and water over long distances, make them more susceptible. Yet, very little research has been done to investigate gender differences in the prevalence of these health conditions, their importance to women, their impact on productivity and well-being, or on how to alleviate them.

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## Gender Inequalities in the Development of Health and Contraceptive Technology

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In a recent review of the safety and efficacy of contraceptive methods, Hardon [23] provides an insightful analysis of the reasons that women's needs may differ from those of family planning programmes and scientists concerned with the development and testing of contraceptive methods. For example, scientists involved in contraceptive development often prefer "provider-dependent" niethods that, once in place, do not depend upon the control of the user. These include implants, injectable contraceptives and intrauterine devices (IUDs). While having the advantage of long-term efficacy without the need for constant surveillance or intervention on the part of the user, such methods place women in a dependent position vis-a-vis control over their bodies. Of even greater concern, especially for women in developing countries who are often under-nourished, anaemic and suffering from reproductive tract and other infections, is the failure of most contraceptive promotional programmes to take into account the social and health contexts of their clients. Clinical trials and acceptability studies are generally conducted in settings where the conditions are carefully controlled by the researchers, with higher hygienic standards than those in real developing country clinical settings [23].

Also missing has been a gender perspective in the dissemination of information concerning the choice of contraceptive methods, especially in developing countries where the focus of propaganda tends to be the couple, represented, in most cases, by the woman. It is often assumed that "meeting a couple's needs for fertility regulation is synonymous with meeting the individual needs of men and women" [25]. This approach fails to take account of needs of unstable families, where partners may change periodically, and of which the numbers are rapidly growing everywhere, or of unmarried adolescents and other individuals, including men. Due to the powerful influence of men on women's decision-making in most cultures, the failure to focus on men's personal desires can adversely affect the outcome of family planning efforts.

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A related issue is the tendency of family planning programmes to rely on female community-based distribution (CBD) workers for contraceptive delivery. A recent study in Lima, Peru, found that the involvement of males led to several benefits to the programme [27], and indicated that men represented a largely untapped potential in this regard. The sales of condoms increased dramatically, as did the number of new clients, mostly males. The authors point out that most successful distributors are those who share common characteristics with the population they serve, and hence males are more likely to be successful when working with male clients. Thus, feniale CBD workers cannot be expected to reach both sexes with equal effectiveness.

In drugs for tropical diseases, women are consistently excluded from clinical trials because of the fear that they may be pregnant or that hormonal status at different times of their monthly cycle may confound the results of these trials. Also, as the hormonal status of women may alter the effect of drugs that are immuno-dependent, there may be variations in their efficacy according to women's hormonal status. Because of lack of research on these interactions, differential effects of newly developed drugs on men and women are unknown and largely ignored. The possible interaction of contraceptive pills with other drugs that women may be using is also an area where more research is needed.

While the unwillingness of drug manufacturers to put women and their offspring at risk through clinical testing is clearly justified, women and children may be unnecessarily excluded from the salutory effects of treatment because of unsubstantiated fears of possible complications. Ways could surely be found to address this problem. Wonien who wish to

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take the drug even when pregnant (and might otherwise conceal their condition) could be Informed about possible risks and asked whether they are willing to participate in prospective studies. Otherwise, retrospective studies of women who had taken the drug accidentally, or because they failed to report their condition, could elicit information on side-effects and possible long-term consequences.

Gender perspectives have also been ignored ın the development of technology for the prevention and control of tropical diseases, despite the fact that it ıs often women to whom the responsibility for utilisation of these technologies on a sustained basis devolves. Bed-nets are a simple example of a preventive measure for malaria that are typically designed without attention to the needs, preferences or sleeping patterns of the populations for whom they are destined. Hence, they have often failed to be adopted and their use sustained. Reasons for this have been poorly understood, or attributed to people's traditional attitudes and behaviour that impede the adoption of modern technology.

Several years ago an intervention undertaken by the Papua New Guinea Health Department to encourage the use of insecticide-treated bed-nets for the purpose of malaria control was found to be unsuccessful ın many parts of the country [28, 291. Social scientists in Papua New Guinea who were familiar with the local culture pointed out that the nets were perhaps unacceptable to local populations because they were a standard size that was unsuitable to many of the rural situations where sleeping arrangements, bed types and cultural factors differed. The researchers proposed an alternative intervention, whereby, the women designed, sewed and sold their own nets to fit the variable requirements of families in their area [29]. . . .

Diagnostic methods for the detection of Infection are generally considered to be objective and purely technical procedures, belonging to the domain of the health professional and laboratory, unaffected by sociocultural considerations. A recent analysis by Feldmeier et al. [5], however, illustrates how gender may affect the diagnosis of schistosomiasis [disease caused by a parasitic flatworm living in blood vessels in the pelvic region], not only because of cultural factors inhibiting women from reporting for treatment but also because of inherent biases in the diagnostic techniques themselves. For example, urine analysis re-agent strips for the detection of blood in urine from S. *haematobium* may be less effective in diagnosing the disease, as well as the intensity of infection, in women than in men. The vast majority of studies performed on the efficacy of re-agent sticks have been conducted on male school children and few have included females. The contamination of urine with menstrual blood could lead to false-positive results, and contamination of samples with such blood or bleeding associated with the complications of schistosomiasis in the vagina, cervix or endometriuni may result in over-estimation of heavy infections in women. Ultrasonography, another widely used method for the detection of schistosomiasis pathology from both the urinary and intestinal forms, may not be acceptable to females in many developing countries because it requires uncovering the abdomen, and in the case of S. haematobiurn, the pubic area. Thus, females may not consent to examination, or may be less thoroughly examined than males. The authors conclude that the accepted view of scientists that ultrasonography is an "excellent" diagnostic method "attractive to individuals" may not apply if a gender analysis is performed [32].

These are only a few examples of a lack of gender perspective in the development of health-related technology. Given women's complex life cycle, including hormonal changes during puberty, pregnancy-related immunological changes and those related to menopause, the applicability of the male model is questionable. Attention to gender differences, especially in developing countries where biological differences between males and females are compounded by inequities in access to adequate food, nutrition and health care, can yield important insights for further research and interventions.

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## Lack of Gender-Sensitivity in the Provision of Health Services

. . . In this section, three important aspects of the framework are discussed with reference to women's health more broadly. These include patient-client communication, interpersonal relations and follow-up. These indicators are selected because some empirical information is available with reference to women's health beyond reproduction and contraception.

### Patient-client communication

One of the main factors inhibiting women's use of health services is the often unsatisfactory nature of the information received. Women in most cultures have a central role as health providers in the family, a role that is strongly valued by women themselves and recognised and respected by others. It is widely reported that women in many cultures prefer traditional healers because they provide meaningful explanations of their illness, whereas modern health providers tend to give limited information, instructing women regarding procedures they should follow rather than explaining how the problem can be treated and what steps can be taken to avoid it in the future [34, 351. . . .

Lack of appropriate information is further hampered by power structures in many developing countries where health education messages are often provided in the form of written messages or coniplicated pictures that cannot be read or understood by rural women. Even if men are able to grasp the meanings, they may not discuss this information with their spouses and others in the family. Gender relations may also prevent women from using information because they must first seek the consent of their husbands or other more dominant family members such as the mother-in-law. . . . Another dimension of patient-client communication that has not received sufficient attention is the failure of health workers to provide complete information to women that could be of considerable concern and utility to them. This is sometimes due to the fact that, in many developing countries, health care providers are overworked and underpaid, and often have neither the time nor the energy to provide long explanations to their clients. They may also make a *priori* and Incorrect judgements concerning women's ability to comprehend and utilise information.

Such lack of attention to the provision of information can cause unnecessary concern to women who later experience unexpected side-effects of treatment. For example, Mull et al. noted that female leprosy patients in Pakistan were not told that clofazimine, one of the drugs in rnultidrug therapy regimen, causes dark stains on the patient's face. Nor did they warn women that rifampicine, another of the drugs, could make body fluids turn a red-orange colour, even though this is known to be a reason for non-compliance among patients [37]. Thalidomide, a drug that is provided to some leprosy patients to relieve pain associated with ENL (erythema *nodosum leprosum),* is contraindicated for women of childbearing age, yet in Brazil, several cases of deformed babies have resulted because women were not informed that they were at risk [38].

Failure to listen to women's concerns may also lead to Incorrect prescribing behaviour on the part of the health provider. For example, providers should assure that women to whom IUDs are prescribed are not suffering from reproductive tract infections. Failure to check women's general health status before prescribing or inserting birth control methods may lead to unnecessary suffering on the part of the clients and ultimate rejection of contraceptive use.

### Interpersonal relations

Interpersonal relations include how clients are treated by health services staff, whether privacy and confidentiality are assured, whether health personnel are respectful and responsive, length of waiting time and time spent with clients [33, 391. In health facilities of many developing countries, these conditions are absent or Inadequately met. Privacy is often difficult to obtain, and even forbidden by cultural norms, as in many Islamic societies

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where female patients cannot be examined by male doctors unless the husband or other male relative is present.

Many researchers have noted that female patients are treated rudely by health professionals and blamed for coming late for treatment [40]. Hardon cites numerous cases in which unsatisfied users of family planning were refused help when they requested that their implants be removed [23]. . . .

A sympathetic attitude on the part of health providers may also facilitate their ability to diagnose and prescribe treatment. In a study of female patient-doctor relationships in Norway, for example, Malterud found that a single key question: "What would you really most of all want me to do for you today?" [43, p. 211] was more effective in eliciting patient responses than a series of medically-oriented questions concerning the patient's ostensible ailment. It also allowed the professional to quickly focus upon gender-based problems of the patient, often of emotional origin, rather than on the symptoms of these problems alone. Research on such strategies in developing countries could be very useful in identifying ways to improve interpersonal relationships between female patients and health providers.

## Follow-up

Related to the provision of information and interpersonal skills is the need for follow-up or appropriate advice for follow-up. Failure to return for subsequent check-ups or treatment may endanger the life of the patient, yet this may not be fully explained by the health provider during the first encounter. . . .

In an ongoing study of pregnant women infected with Chagas disease in Argentina, lack of communication and follow-up among hospital departments seriously inhibited women from taking positive action for follow-up [45]. Women were required to consult several different services, including maternity, neonatology, paediatrics, laboratory, psychology and social work. As mechanisms for communication among the services did not exist, the results from one department were not available to the others. In the case of serology, women theniselves were required to pick up the tests from the laboratory and deliver them to the maternity service. Not surprisingly, many women did not return for further examinations.

## Gender Perspectives in Health Policies

Health policies in developing countries are usually developed by highly placed male policy-makers who fail to take gender considerations into account when considering the potential impact of alternative strategies. In a review of participatory health approaches that have become popular in the past two decades, Leslie et al. observe that, although women were not often consulted in the conceptualisation of these policies, their success has largely depended upon women's involvement [46]. Taking the examples of primary health care and the child survival revolution, they show that women's tasks are central to the various activities promoted, such as the provision of water and sanitation, nutritious food, treatment of common diseases and injuries, and maternal and child health (including family planning). The four GOBI strategies of child survival — growth monitoring, oral rehydration therapy, breastfeeding and immunisation — clearly illustrate this argument. These roles are expected to be undertaken in a more effective way, thus requiring an increased time commitment on the part of women, while not necessarily providing tangible benefits to them. The promotion of breastfeeding is motivated more by a concern for the child's health than the mother's, and there has been little attempt to take into account women's needs and time constraints. If, however, these strategies are accompanied by appropriate time-saving, health-promoting interventions, such as safe water and food subsidies, women could also profit in time saved and in better health status for themselves and their families.

Leslie et al. [46] also discuss the impact of structural adjustment policies, aimed at eliminating economic distortions and

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pronioting sustainable growth, on women's health in developing countries. The policies include cuts in public investments in the social sector, such as education, health and the privatisation of many services, including health care, removal of subsidies for the poor and other vulnerable groups, increases in prices for services such as drugs, water and school supplies, the devaluation of local currencies and export-oriented production in agriculture and industry. . . .

Results from recent studies on the impact of structural adjustnient policies are not entirely consistent. There is widespread agreement that women will be more affected economically by these policies because they are poorer, and that they will have fewer resources to pay for care than men. Many have argued that these policies have had adverse effects on the health of the poor in developing countries, and especially on women [46, 48, 491. These effects, it is argued, are compounded by gender socialisation, "which gives women primary responsibility for the care of people (women's roles in social reproduction), without relieving them of the shared responsibility for providing the means for that care (women's role in economic production)" [49, p. 21. Thus, women face the double burden of having to work harder to earn the financial resources to cover health care and other basic needs, formerly available free of charge or at affordable cost.

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In this article, elements of gender bias in traditional health research are discussed at length. The author points out that gender bias results in biased and flawed research in several areas of biology because women are excluded in research, research focus is mainly on problems of primary interest to men, "objectivity" is actually synonymous to male world-view or androcentricity, and in the end, data collected are interpreted in language and ideas constricted by patriarchal values. The author argues that these flaws and biases have become part of the mainstream thought and have been perpetuated in the scientific literature for decades because most scientists were men who did not detect or acknowledge bias. In concluding her analysis, the author puts forward some suggestions to overcome gender bias in clinical research.

# Gender Bias in Clinical Research: The Difference It Makes

by Sue V. Rosser

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## Gender Bias in Traditional Approaches to Clinical Research

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### Androcentric bias in defining priorities for medical research

Recent evidence suggests that gender bias may have flawed some medical research. The choice of problems for study in medical research is substantially determined by a national agenda that defines what is worthy of study. As Marxist (Zimmerman et al., 1980), African American (McLeod, 1987), and feminist critics (Hubbard, 1983) of scientific research have pointed out, the scientific research that is undertaken reflects the societal bias toward the powerful, who are overwhelmingly white, middle to upper-class men in the United States. . . .

### Lack of funding for clinical research on women

Research on conditions specific to females receives low priority, funding, and prestige, although females make up half of the population and receive more than half of the health care. . . .

In contrast, significant amounts of time and money are expended upon clinical research on women's bodies in connection with aspects of reproduction. In this century, up until the 1970s, considerable attention was devoted to the development of contraceptive devices for women rather than for men (Cowan, 1980; Dreifus, 1978). Furthermore, substantial clinical research has resulted in increasing medicalisation and control of pregnancy, labour, and childbirth. Feminists have criticised (Ehrenreich and English, 1978; Holmes, 1981) the conversion of a normal, natural process controlled by women into a clinical, often surgical, procedure controlled by men. More recently, new reproductive technologies such as amniocentesis, in vitro fertilisation, and artificial insemination have become heavily emphasised, as means are sought to overcome infertility. Feminists have warned of the extent to which these technologies place pressure upon women to produce the "perfect" child while placing control in the hands of the male medical establishment (Arditti, Duelli Klein and Shelley, 1984; Corea and Ince, 1987; Corea et al., 1987; Klein, 1989).

Additionally, contraceptive research exclusively on women is problematic. Specifically, this type of biased research has produced birth control methods that permit men to have sexual pleasure without the risk of impregnating women and without the risk of deleterious pharmacological side-effects now experienced by women.

These examples suggest that considerable

resources and attention are devoted to women's health issues when those issues are directly related to men's interest in controlling production of children.

## Failure to recognise the effects of gender

. . . Because many diseases have different frequencies (heart disease, lupus erythematosus), symptoms (gonorrhea), or complications (most sexually transmitted diseases) in the two sexes, scientists should routinely consider and test for differences or lack of differences based on gender in any hypothesis being tested. For example, the study of how a drug is metabolised should routinely include both males and females.

Five dramatic, widely publicised recent examples demonstrate that sex differences are not routinely considered as part of the question asked. In a longitudinal study of the effects of cholesterol-lowering drugs, gender differences were not tested. The drug was tested on 3,806 men and no women (Hamilton, 1985). The Multiple Risk Factor Intervention Trial Group (1990) examined mortality from coronary heart disease in 12,866 men only. The Health Professionals Follow-Up Study (Grobbee et al., 1990) explored the association between coffee consumption and heart disease in 45,589 men. The Physician's Health Study (Steering Committee of the Physician's Health Study Group, 1989) found that low-dose aspirin therapy reduced the risk of myocardial infarction in 22,071 men. A study published in September 1992 in the Journal of the American Medical Association surveyed the literature from 1960 to 1991 on clinical trials of medications used to treat acute myocardial infarction. Women were included in only 20 per cent of those studies; elderly people (over 75 years of age) were included in only 40 per cent of such studies (Gurwitz, Nananda and Avorn, 1992).

The scientific community has often failed to include females in animal studies in basic research as well as in clinical research unless the research centred on reproductive control. The reasons for the exclusion (to prevent interference from estrus or menstrual cycles, to avoid the fear of induction of foetal deformities in pregnant subjects, and to take advantage of the higher incidence of some diseases in males) may be financially practical, but such exclusion results in drugs that have not been adequately tested in female subjects before being marketed and in lack of information about the etiology of some diseases in women.

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## Interaction between gender, ethnicity, and class in research

When women are used in experimental studies, often they are not accorded the respect due to any human being. In his attempts to investigate the side-effects of nervousness and depression attributable to oral contraceptives, Goldzieher (Goldzieher, Moses, Averkin, Scheel, and Taber, 1971a, 1971b) gave placebos to 76 women who sought treatment at a San Antonio clinic to prevent further pregnancies. None of the women was told that she was participating in research or receiving placebos (Cowan, 1980; Veatch, 1971). The women in Goldzieher's study were primarily poor, multiparous, Mexican Americans. Research that raises similar issues about the ethics of informed consent was carried out on poor Puerto Rican women during the initial phases of testing the effectiveness of the pill as a contraceptive (Zimmerman et al., 1980). Recent data have revealed that at certain clinics, routine testing of pregnant women for HIV positivity was carried out without their informed consent (Chavkin, Driver, and Forman, 1989; Marte and Anastos, 1990). Subsequently, pressure was placed on those women who were HIV positive to abort their foetuses (Selwyn et al., 1989).

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## Reciprocal relationship between research and female subjects

Most current clinical research sets up a distance between the observer and the human subject. Several feminist philosophers (Haraway, 1978; Harding, 1986; Hein, 1981; Keller, 1985) have characterised this distancing as an androcentric approach. Distance between the observer and experimental subject may be more comfortable for men, who are more comfortable with autonomy and distance (Keller, 1985), than for women, who tend to value relationship and interdependency (Gilligan, 19821.

Suggestions for relevant research questions

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based on the personal experiences of women also have been neglected. In the health care arena, women have often reported (and accepted among themselves) experiences that could not be documented by scientific experiments or were not accepted as valid by the researchers of the day. For example, for decades dysmenorrhea was attributed by most health care researchers and practitioners to psychological or social factors despite the reports from an overwhelming number of women that these were monthly experiences in their lives. Only after prostaglandins were "discovered" was there widespread acceptance among the male medical establishment that this experience reported by women had a biological component (Kirschstein, 1985). Thus, researchers should make an effort to include qualitative experiences and insights of women in the design and implementation of research on women. Using only traditional scientific methods may result in failure to obtain sufficient information about the problems being studied. Ironically, this is particularly true of the research on pregnancy, childbirth, menstruation, and menopause because these experiences, which are exclusive to women, have been studied almost entirely by methodologies created by men.

## Androcentrism in theories and conclusions in research

An androcentric perspective may lead to the formulation of theories and conclusions drawn to support the status quo of inequality for women and other oppressed groups. . . .

The traditional rationale to support "objective" methods is that they prevent bias. Emphasis upon traditional quantitative approaches that maintain the distance between observer and experimental subject ostensibly removes the bias of the researcher. Ironically, to the extent that these "objective" approaches are in fact synonymous with a masculine perspective of the world, they may introdu e bias. Specifically, androcentric bias may permeate the theories and conclusions drawn from the research in several ways.

Theories may be presented in androcentric language. Much feminist scholarship has focussed on problems of sexism in language and the extent to which patriarchal language has excluded and limited women (Kramarae and Treichler, 1986; Lakoff, 1975; Thorne, 1979). Because language shapes our concepts and provides the framework through which we express our ideas, sexist language is a reflection of underlying sexism. An awareness of sexism as expressed through patriarchal language enables feminist researchers to describe their observations in less gender-biased terms. Such an awareness must be extended to all researchers, both men and women. . . . The limited research on HIV/AIDS in women focusses on women as prostitutes or mothers. Describing the woman as a vector for transmission to men through prostitution or to the foetus has produced little information on the progress of HIV/AIDS in women themselves (Rosser, 1991). Once the bias in the terminology is exposed, the next step is to ask whether that terminology leads to a constraint or bias in the theory itself.

## Inequities in health care practices for women

Not a surprise, androcentric bias in research has resulted in differences in management of disease and access to health care procedures based on gender. In a 1991 study in Massachusetts and Maryland, Ayanian and Epstein (1991) demonstrated that women were significantly less likely than men to undergo coronary angioplasty, angiography, or surgery when admitted to the hospital with the diagnosis of myocardial infarction, unstable angina, chronic ischemic heart disease, or chest pain. This significant difference remained even when variables such as ethnicity, age, economic status, and other chronic diseases such as diabetes and heart failure were controlled.

A similar study (Steingart et al., 1991) revealed that women have angina before myocardial infarction as frequently and with more debilitating effects than men, yet women are referred for cardiac catheterisation only half as often. The 1992 Journal of the American Medical Association study concluded that the exclusion of women from 80 per cent of the trials and the elderly from 60 per cent of the trials for medication for myocardial infarction limits the ability to generalise study findings to the patient population that experiences the most morbidity and mortality from acute myocardial infarction (Gurwitz et al., 1992). Gender

bias in cardiac research has therefore been translated into bias in management of disease, leading to inequitable treatment for life-threatening conditions in women.

## Overcoming Gender Bias in Clinical Research

Recognising gender bias is the first step toward understanding the difference it makes. . . . To eliminate bias, the community of scientists undertaking clinical research must include individuals from as many diverse backgrounds as possible (Rosser, 1988). Only then is it less likely that the perspective of one group will bias research design, approaches, subjects and interpretations.

Similarly, researchers need to consider the influence that they have on the design, implementation, and conclusions of their studies, based on a variety of personal characteristics including their own ethnicity/culture, class, age, education, functional ability and gender (Swigonski, 1993). In other words, researchers should acknowledge that most scientific endeavours, even one's own, are value laden. Biases, as well as their possible effects on the research, should be identified throughout the research process (Swigonski, 1993).

Cross-disciplinary or multidisciplinary research methods are needed to ensure a comprehensive understanding of women's experiences from a variety of perspectives. For example, if the topic of research is occupational exposures that present a risk to the pregnant woman working in a plant where toxic chemicals are manufactured, it would be best to use a combination of methods traditionally used in social science research with those frequently used in biology and chemistry. Checking the chromosomes of any miscarried foetuses, chemical analysis of placentas after birth, as well as Apgar Scores and blood samples of the newborns to determine trace amounts of the toxic chemicals would be appropriate biological and chemical methods to gather data. Methods used in social science research such as in-depth interviews with women to determine how they are feeling and any irregularities they detect during each month of the pregnancy would be appropriate as well. Evaluations using weekly written questionnaires regarding the pregnancy progress also would enhance the research process. . . .

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Set within the context of India, this article gives strong arguments why there should be a focus on women's health. The reasons given are: women's health must be seen as an end in itself; women have multiple needs and roles; and improving women's health directly improves women's social advancement, fertility reduction and labour. The author quotes several references to other contemporary analytical perspectives on gender and health issues in India to add credibility to her point. Finally, some ideas for research and action priorities are suggested, particularly in neglected areas like abortion, sexually transmitted diseases including HIV/AIDS and contraceptive safety.

# Gender and Health: From Research to Action

by Adrienne Germain

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## Premises for Action

To clarify perceptions about women's health and the context which affects it, it is important to specify the underlying values and justifications for attention to women's health. There has been a strong tendency to adopt rather narrowly defined cost/benefit criteria in allocating health resources. In the case of women's health, most actions to date have been justified as means to control fertility or to improve child survival. In this paper, I propose the following premises for action:

### Women's health should be an end in itself not just a means to achieve other ends

Dilemmas arise when women are seen largely or solely as means to other ends. For example, it is sometimes suggested that the children of working women may suffer from their mothers' absence from the home. Are we then to conclude that mothers should not work? Or should we provide child care services? Health policies that emphasise maternal and child health and family planning do not meet the needs of older women or, often, young people aged five to 16. Chen and Drèze illuminate the plight of older women and widows whose needs are not well served by existing programmes. Recognising women's health as an end in itself requires serving women throughout their lives. It also requires development of a better balance between the quantity and quality of services offered.

### Women have multiple needs and responsibilities

Several papers (including Basu, Sundari, Jejeebhoy and Rama Rao) underline the importance of improving services. The major need is to ensure that national programmes provide at least minimum services routinely and efficiently with respect for the women. Examples include integrating health and nutrition programmes; clarifying the appropriate roles of various levels of health personnel, especially fostering the appropriate involvement of lower levels of personnel; and setting appropriate goals (e.g., is it appropriate and necessary to achieve hospital delivery for all pregnant women as some suggest, or is it most beneficial to assure attendance by a trained person at home or at the local health centre-level, with strong referral and transport facilities for emergency cases?). Several papers in this volume highlight the failures of current, narrowly vertical programmes and some warn against adopting a similar strategy for AIDS prevention. What is needed is to learn from existing integrated efforts and to assess their

possible application in large-scale health programmes. Several papers also assert that more domiciliary services are needed to provide care to women who otherwise could not have it because they are too poor, opportunity costs are too high, their movement is too restricted by norms of seclusion, and they are constrained by myriad other factors.

### Investments in women's health can have beneficial ripple effects

Kerala's experience underscores the value of giving priority to women's health services, and to the training and development of female health workers (Kabir and Krishnan, 1994). While Kerala is distinct, its experience does provide very important lessons and insight regarding how investments in women's health, broadly defined, can have powerful beneficial ripple effects into social advancement, fertility reduction and labour productivity.

### Women's social disadvantage should be reduced

[This is in order] to prevent poor health and to create effective demand for health care and fertility control. Chen and Drèze also point out that investment in girls' and women's health, and in improving other aspects of women's status, will affect fertility levels, as well as child survival, through changes in reliance on sons for old age security.

These premises for action will require modification in deeply held social values, existing budget allocations, standard programme strategies, and the "conventional wisdom" of the health and family planning field. Many recognise that advocacy and political action for women's health will be essential. These basic premises point toward action and research priorities as presented in the next section.

### Action and Research Priorities

The suggestions below are not meant to be comprehensive. Rather, they are indicative of actions needed from the point of view of women's health, in the context of overall health planning and development. The proposed list of priorities begins with research, but research is not the only priority. Rather, it is essential that action be taken even though existing data and research are incomplete. Action programmes themselves provide excellent opportunities for learning. If research and documentation efforts are built into action programmes from the beginning, research and action can be effectively integrated, an iterative process, with synergistic impact.

### Research

From women's perspectives, and more generally, it is essential to examine the human realities behind macro-level data. Disaggregation of gender-specific data by sub-region, urban/rural, age, caste, and other social categories would also be helpful. Excellent examples of the insights gained are provided by the Chen and Drèze paper. At the same time, Jejeebhoy and Rama Rao have clearly identified important areas of women's reproductive health for which neither micro nor macro-level data exist, e.g., induced abortion and sexually transmitted diseases (see also Ramasubban). The Government of India's expressed concern about AIDS prevention and control could provide an excellent opportunity to begin to investigate the latter systematically.

We need to know much more about women's perceptions of their own health, their utilisation of the full range of health services (from ayurvedic to allopathic), and their service preferences. At the same time, we need to examine much more closely our understanding of the determinants of women's health and gender differentials in health. The variables referred to in several papers—such as age at marriage or education—are relatively easily quantifiable. Other crucial variables, such as "status", gender-based power relationships, "custom and culture" remain weakly understood "black boxes", though they are very often invoked as major determinants of women's health.

## Services

The central question is: are the current emphases of health services appropriate and are such services delivered in such a way as to meet women's needs? Special attention is needed on neglected issues, including safe abortion, sexually transmitted diseases including AIDS, and contraceptive safety.

## Broad social action

Ultimately, as Jejeebhoy and Rama Rao and others suggest, reductions in the morbidity and mortality among girls and women depend upon changes in broader social structures which restrict girls' and women's ability to value and maintain their own health, their status and their rights. In the shorter term, advocacy for increased attention to girls' and women's health is required.

## Changes in male-centred social attitudes

Many health problems that are specific to girls and women are the result of gender discrimination and ultimately derive from male-centred social attitudes and behaviours, whether from spouses or policy-makers. Changes in male attitudes and behaviours are urgently needed. The first step is to recognise that these are central to girls' and women's health disadvantages. We can then move forward to reduce gender differentials and to meet the special health needs of women consequent to their sexual and reproductive functions.

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This article provides a strong case for the need for a women's health curriculum in medical activities, namely in research, medical education and clinical practice. Six fundamental reasons are given which are: a) fragmentation between different medical specialties; b) the differing biological needs of women compared to men; c) women's roles as health care providers; d) women's morbidity/mortality due to gender bias in research, medical education, and clinical practice; e) to increase the number of female medical students and doctors; and f) gender bias in all three areas of research, medical education and clinical practice. In the final part, a framework is used to assess gender bias in all of these medical activities.

# Why a Curriculum on Women's Health?

by Lila A. Wallis

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## Reasons for a Women's Health Curriculum

There are six basic reasons for the development of a women's health curriculum:

### Fragmentation

Too often women's health needs get lost in the gaps between different medical specialties. Women are referred back and forth between gynaecologists, internists, family practitioners, and various other specialists. A woman seldom receives thorough, comprehensive care as an individual, with attention to all her organ systems.

Fragmentation is expensive, wasteful, and generates resentment in a woman whose brother is not being referred by an internist to a urologist for male genitorectal exam. Why must women go to another specialist for a routine pelvic examination and pap smear?

### Differences between men and women

The second reason is that women are different than men. It is not true that "apart from reproductive function—women's health is like that of men's health" (Harrison, 1992). Differences in women's health supersede the boundaries of the reproductive tract and affect every system: cardiovascular (Becker and Corrao, 1990; Bush, Fried, and Barrett-Connor, 1988; Castelli, 1988; Corrao, Becker, Ockene, and Hamilton, 1990; Eaker, Packard, and Thom, 1989; Eaker et al., 1987; Faludi, 1992; Wallis, 1992; Wenger, 1991; Wingard, 1990), gastrointestinal (Frezza et al., 1990), immune (Grossman, 1985), resistance to infection (HIV) (Agosti, 1991; Chu, Buehler, and Berkelman, 1990; Imam et al., 1990; Maiman et al., 1990; Spence and Reboli, 1991; Stein et al., 1991), and musculoskeletal, urologic, and psychological health (Women and Health Roundtable, 1985). The physiological hormonal milieu and environmental, societal, and economic circumstances shape the course of illness and therapeutic outcome differently in women than in men. Gender differences in the metabolism of pharmaceutical agents are also well documented (Hamilton and Parry, 1983).

### Women's dual role

The third reason is the dual role women play as receivers of health care. Women act as a distribution channel of health care to spouses, children and parents. At the same time, women are the major source of criticism and resentment directed at the medical profession; women increasingly resent receiving second-class care (Corea, 1977/1978).

## Morbidity/mortality

The fourth compelling reason to develop a women's health curriculum is that women suffer and die as a result of the gender bias in research and medical education. Inadequate research translates into inadequate education and training of physicians and into inappropriate clinical care.

While women succumb to arteriosclerotic heart disease later in life than men, female *mortality* after a myocardial infarction is higher than for males (Corea, 1977/1978; Dittrich et al., 1988; Fiebach, Viscoli, and Horwitz, 1990; Greenland, Reicher-Reiss, Godbourt, and Behar, 1991; Kannel and Abbott, 1987; Lerner and Kannel, 1986).

Thrombolysis therapy is associated with more side-effects, including haemorrhage, in women (Becker, 1990). After an angioplasty, female blood vessels close off more readily than those of men (Cowley et al., 1985). The female mortality after bypass surgery exceeds that of men (Douglas et al., 1981; Khan et al., 1990; Lopp et al., 1983).

There have been many explanations of those gender differences. And controversies exist over whether the differences are biological or result from bias (Bickell et al., 1992; Krumholz et al., 1992; Laskey, 1992; Steingart et al., 1991; Wenger, 1990). The problem remains, however, that little or no research has been directed at the resolution of the question and no research at all directed at possible remedies.

## Role of women physicians

Why now? The reason for developing a women's health curriculum now is the increase in the numbers of female medical students and female doctors. Women physicians have always felt responsible for the health of women and children. . . . Increasing numbers of women physicians take on as their personal goal filling the gaps left by medical school education, which is defective in women's health issues, and the gaps left by the various specialty training programmes. While there is well-documented need for further research into women's health (Healy, 1991a; Nadel, 1990; US Public Health Service, 1987), there is a feeling that much that is known about women does not get communicated to practitioners and does not get incorporated into the health care of women.

## Gender bias

The basic reason for the development of a women's health curriculum is to undo the damage brought on by *gender bias* in medical education, research, and clinical practice. Gender bias is inherent in a male-dominated, male-taught discipline.

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In constructing the classification of gender bias in medicine, I have used the schema first proposed by Drs. Eichler, Reisman, and Borins (1988; Eichler, 1988) for assessing medical research for gender bias, and I have expanded it to cover all activities in medicine (education, research, training, and practice) as well as adding another manifestation, that of failure of identification.

The five main manifestations of gender bias are as follows:

- **Androcentricity**—a view of the world from a man's perspective. In medical education, it can take various forms, including female invisibility or use of a male frame of reference. For instance, first-year medical students are taught that women are different than men. In physiology classes, they are told that the average weight of a human being is 70 kg and, parenthetically, that of an aberrant species (women) is 50 kg. Similarly, the blood values for women indicate, by male standards, a mild anaemia.

  Now, contrasting this presentation, one finds that the difference between the sexes indicates relative mild polycythemia in men. But by constantly using the male frame of reference, the professor teaches the student that women are a minor aberration of the species *Homo sapiens*. This engenders an attitude toward women patients that is both alienating and patronising.

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- **Over-generalisation** occurs when a study includes only one sex but presents itself as if it were applicable to both sexes. For example, in the February 15, 1992, issue of a respected medical journal, a paper appeared titled *Chronic Chlamydia Pneumoniae Infection as a Risk Factor for Coronary Heart Disease in the Helsinki Heart Study* (Saikku et al., 1992). The gist of the study was that chronic Chlamydia infection may be a significant risk factor for developing coronary heart disease.

  The gender of the patients was not mentioned in the title or in the structured abstract. It was not until well into the discussion that the reader discovers that only men were tested. Women were not tested even though chronic infection with a related species Chlamydia trachomatis is prevalent in women. More important, not including the gender of subjects in the title or abstract was another example of assuming that the male is the generic human.

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- **Gender-insensitivity** consists of ignoring sex as a socially or medically important variable. Lack of knowledge of sex differences and similarities impedes appropriate progress in subsequent research, making it impossible to devise gender-sensitive treatments for women and men. Many psychotropic medications were tested on the males of the species even though these medications are clinically used mostly in women (Hamilton and Parry, 1983).

  Of course, studies done on men do not necessarily apply to women at all. Women are different biological entities, with different hormones, different patterns of health and disease, and different responses to stress. No one does a study on a group of women and then assumes the results apply to men, but the reverse happens again and again.

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- **Double standards** involve evaluation, treatment, or measurement of identical behaviours, traits, and situations by different means. Women have repeatedly complained that doctors do not take them seriously, that their symptoms are waved aside as imaginary. In San Diego, a research team investigated the way that physicians responded to five medical complaints common in both men and women: chest pain, back pain, headache, dizziness, and fatigue (Armitage, Schneiderman, and Bass, 1979). They examined the extent of the work-up ordered on patients with these complaints and found that, across the board, men received a more extensive work-up than women for all complaints studied. The difference could not be explained in terms of medical facts alone and suggested that (perhaps), in fact, physicians did not take complaints as seriously when they came from women.

  This double standards attitude may also explain the results of the classical Tobin et al. (1987) study of sex bias in considering coronary bypass surgery. The investigators looked at patients with abnormal cardiovascular radionuclide exercise scans: 40 per cent of the men but only four per cent of women with abnormal test results were referred by their physicians for cardiac catheterisation. This 10:1 ratio was independent of age. Once again, for the same symptoms, and even for the same abnormal test results, women got less medical attention. The authors raised the question of whether coronary artery bypass surgery is under-used in women. . . .

- **Failure of identification leads to failure of interest**. . . . Medical research depends on grant money, which also depends on the prejudices of those in power, on what they think is interesting, important, mainstream. In addition, men have traditionally been the wage earners. Society is hypnotised by the image of the "hot-shot" businessman, struck down in his vigorous prime by a sudden heart attack. Health risks to those at the top of the social heap, those who are visible and important, successful and respected, have

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been a powerful impetus to research, and those who fund the studies, and those who carry them out, are looking for information about the dangers that threaten close to home. The health risks of the housewife just have not seemed as pressing.

A failure of identification says that, *"if we don't feel it, it doesn't exist"*. Failure of identification leads to that pervasive stereotype of the woman as complainer, as someone who manifests her mental woes in physical symptoms, such as the hysteric, the neurasthenic, about whom the physician does not have to be too concerned; her headaches or her chest pains are imaginary. Dysmenorrhea and PMS are written off as psychosomatic.

But even when faced with scientific evidence that physical disease exists, physicians react differently to that evidence in men, taking it more seriously. Heart disease became a male disease; in the eyes of those physicians: "the 70 kg man needs bypass surgery."

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The same reluctance to identify with the female patient has led to rough, painful, inconsiderate, uncommunicative, hurried, incompetent pelvic exams and superficial and incompetent breast exams. It wasn't until 1979 when we started the Teaching Associates Program at Cornell, followed by many other medical schools, that we determined that pelvic exams need not be painful, insensitive, and embarrassing (Guenther, 1984; Wallis, 1984; Wallis and Jacobson, 1984; Wallis, Tardiff, and Deane, 1984).

Why are mammograms so painful to many women? If it were a routine procedure for male patients, somebody would have long ago modified the equipment to prevent the pain.

A paradigm based on male needs does not serve women patients well; women have different patterns of health and disease. Complications of hypertension, for example, appear an average of ten to 15 years later in women than in men. Diseases such as rheumatoid arthritis and lupus erythematosus are much more common in women. Anxiety disorders and depression are much more common in women, while men have at least twice the rates of anti-social personality and alcohol abuse/dependency. Alcohol abuse in men leads most commonly to violence; in women, to depression.

Urologists, who are almost exclusively men, have spent much of their time dealing with prostate problems. Women have urologic problems too, such as cystitis, urethritis, the "honeymoon pyelitis", the poorly understood "interstitial cystitis", and the various forms of urinary incontinence, problems that have received less medical attention and less interest in research. One reason is that there are few female urologists to identify with the female patient.

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Medical school education and physician training programmes have over the centuries reflected male attitudes and interests and many of women's health needs are left unattended or fragmented. Hundreds of individual women physicians, having confronted the unmet needs of their patients, went on to take additional courses and informal preceptorships to fill the gaps in their training. This process has been largely haphazard, intuitive, and unorganised and guided by the individual physician's perception of the needs.

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This article examines the prevalence of mental disorders in China and some of the contributing social factors from a gender perspective. The author bases her analysis on two sets of data—national epidemiological data on mental health and empirical data that she had gathered from her psychiatric hospital and ward surveys. Data on four different mental conditions (schizophrenia, depression, suicide and neurosis) are reviewed. Comparisons with data from Western countries are made to show some areas of commonality and differences as well as to point out the contributing factor that are specific to China.

# Goods on Which One Loses: Women and Mental Health in China

by Veronica Pearson

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Bernandez [3] suggests that there are four social factors affecting the mental health of women. The first is the way in which they are socialised into their conception of normal female behaviour. Such behaviours may come to be regarded as natural when in fact they are not and non-conformity interpreted as "illness" or deviance. Second, if women as a category are clearly defined as second class citizens and have a lower social status than men, this is likely to have a deleterious effect on the psyche of individual women. Thirdly, discrimination in education, employment and other formal sectors may lead to bitterness and frustration. Fourth, the health professionals from whom they seek help may be as influenced by cultural stereotypes as laymen and consequently reinforce behaviours or set standards that are profoundly unhelpful for individual women.

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## Epidemiological Data on Mental Health

The most comprehensive study of psychiatric disorder in China is known as the *Twelve Centres Epidemiological Survey,* and was carried out with the advice and assistance of the World Health Organization [27, 28]. A review (in English) of all the surveys in this area carried out in China is contained in Cheung [29], but it ignores gender differences.

### Women and schizophrenia

The *Twelve Centres Epidemiological Survey* found that the point prevalence rate for schizophrenia was 6.00/1,000 in the urban areas and 3.42/1,000 in the rural areas [30]. Leff [31] gives prevalence figures from a variety of countries, ranging from 0.9–8.0/1,000 suggesting that the Chinese figures are within an expected range. There was a marked gender difference in the Chinese sample. The lifetime prevalence rate for women was 7.07/1,000 and for men 4.33/1,000. This difference held good in both urban and rural areas and was significant at the <0.01 level [32]. Thus, the rate for women was almost double that for men. Chen [32] attributes these differences to the higher psychological and social burdens that women have to bear.

To the Western eye, one of the most remarkable aspects of the results from the *Twelve Centres Epidemiological Survey* is that apparently, significantly more women than men suffer from schizophrenia. Phillips and Pearson [33] have expressed some reservations about case finding in the *Twelve Centres Epidemiological Survey* in relation to the large urban/rural difference in the occurrence of schizophrenia. The gender differences may also

be an artifact of case finding methods. If they reflect a true difference, this would be a most unusual circumstance.

No national statistics are kept of the distribution of psychiatric beds by gender. Even the officially reported numbers of hospital beds are likely to be unreliable [34]. Thus, any suggestions must be tentative. However, I have visited at least 15 psychiatric hospitals in China and in all those where the provision of beds was a response to the demand from the community, male beds outnumbered female beds by at least 6:4 and sometimes more. This was also found in a study of three psychiatric hospitals in China [35]. Thus, we have a situation where according to the most scientifically conducted epidemiological study so far, there is a significant excess of female patients suffering from schizophrenia, but an equally significant preponderance of beds for males. Between 75–80 per cent of psychiatric hospital beds in China are occupied by people diagnosed as suffering from schizophrenia (both men and women), so these figures are not a reflection of admissions for different illnesses between sexes.

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[One of the] effects that gender role expectation can have on bed occupation patterns was suggested by several Chinese psychiatrists, who thought that women feel a greater sense of responsibility towards parents, husbands, and children and are consequently more reluctant to be admitted and tend to stay for shorter periods of time (at least in the acute sector).The obverse of this is that families cannot function very efficiently without the mother/wife in the house, so that pressure is put on women to return home as quickly as possible. Men, on the other hand, particularly those working in enterprises and covered by health insurance, are pleased to be relieved of work and tend to prolong their stays.

In both hospital studies, it became apparent that there were significant differences regarding the payment status of men and women. In the long-term hospital, 19.4 per cent of all the men were supported by the health insurance provided by their employer. This was true of only ten per cent of all the women. Thus, proportionately more women were "charity" cases of having to be supported by their families.

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## Women and depression

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It could be argued that the greater prevalence of depression in women in both Western countries [44–46] and Chinese societies is an indication that the tendency to develop depression is biologically-based. An equally plausible hypothesis is that women, sharing a disadvantaged status, have more to be depressed about. In support of this view, McGuffin and Katz [47] were unequivocal in stating that the findings from their study led them to the conclusion that most of the gender differences between the sexes, regarding the prevalence of depression, are due to environmental factors.

The tendency of Chinese doctors to over-diagnose schizophrenia and under-diagnose depression and bipolar disorder is well documented [28, 29, 48–51]. This is also my impression based on reading hundreds of case files, and interviewing with Chinese psychiatrists. It has been suggested that someone who is quietly depressed, withdrawn and uncommunicative, is relatively acceptable in a Chinese society that values self-contained and decorous behaviour [52, 53]. Those that come to the notice of doctors are those whose behaviour brings them to public attention.

## Suicide

This argument is certainly plausible, but does not mean that depression is rare, only that it goes undetected. Evidence to support this view comes from an examination of suicide statistics, a subject on which the Chinese authorities are notably silent. Information comes largely from two sources, a World Bank report [54] and a study by Li and Baker [55] . . .. The top three causes of injury death in China are suicide (33 per cent), motor vehicle crashes (16 per cent), and drowning (14 per

cent). In America, death by suicide accounts for 20 per cent of all injury deaths. . . . the suicide profile in China differs from that in the West in that there are more completed suicides amongst women than men.

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Such high levels of suicide must reflect the social, cultural and economic changes that the Chinese society is facing. Such issues seem to bite hardest in the rural areas generally, but affect young women most seriously, among whom suicide seems to be a silent epidemic. Li and Baker [55] speculate that marriage problems and poverty may be the major causes of suicide for this group of women.

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### Women and neurosis

The *Twelve Centres Epidemiological Survey* found very low rates of neurotic disorder, defined to include hysteria, hypertension, anxiety, phobic conditions and depression [56]. Out of a total sample of 6,952 people interviewed, only 16 cases of neuroses in men and 134 in women were found. Xiang [56] explains this by saying that Chinese doctors are diagnosing neurasthenia when faced with symptoms which Western doctors would identify as neurotic [57, 58]. The overall female rate is 39.93/1,000 (urban 37.21/1,000; rural 42.69/1,000). The overall male rate is 4.71/1,000 (urban 4.22/1,000; rural 5.18/1,000). If one accepts the level of neurotic disorder as a measure of distress, then women would appear to be more affected than men. However, a confounding factor is neurasthenia, which is treated as a physiologically-based disorder in China. We do not know whether doctors tend to diagnose neurasthenia more often in men (a physical disorder) and neurosis more frequently in women (a psychological disorder). If one looked at the combined figures for both these disorders, a more equal pattern might emerge. In the current state of our knowledge, it is not possible to know.

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## Conclusions

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Official policy in China strongly condemns discrimination against women. Equality between the sexes is clearly specified in the Constitution and a new law has been passed to protect women's rights and interests. However, policy in this area suffers difficulties common to policy formulation in the People's Republic generally; namely that the central authorities do not have the necessary power or control over resources to make the provinces implement centrally devised strategies. The government claims that current discrimination against women is the result of remnants of feudalistic thinking and to a limited extent that may be true, for instance, in the preference for sons to continue the family name. But, it is also the case that current government policies have contributed to continued discrimination. Examples are the "one-child" policy and the pursuit of a "socialist market-economy", where profit outweighs all other considerations and employing women is considered to be less profitable. Thus it is possible to demonstrate, that despite government policies to the contrary, there continues to be significant discrimination against women in China, particularly in rural areas.

On a macro-level, clear gender differences are seen in the suicide rates, which are much higher for women than for men, particularly amongst young women in rural areas. These women are most vulnerable, not only because of the paucity of life chances and choices available in the rural areas (true for both sexes) but because it is the age at which they are most likely to marry, and begin to suffer at the hands of husband and mother-in-law, especially if they bear a daughter. In truth, the suicide statistics in China indicate that life is hard for both men and women.

Women are diagnosed with depression and neurosis significantly more often than men (as

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they are in Western countries), although depression, in comparison with Western norms, is diagnosed comparatively infrequently. The epidemiological data for schizophrenia are unusual, indicating that significantly more women than men suffer from this illness, whereas the *International Pilot Study* suggests that schizophrenia occurs equally in men and women [41]. However, although no national figures are available, what is known suggests that there are fewer psychiatric hospital beds occupied by women. Evidence is also produced that suggests that the amount spent on treatment for women may be significantly less than that on men. This is certainly a product of women having less health insurance. Thus, they are more reliant on family resources to pay for their hospital treatment. Families may be financially unable to do this, or unwilling to commit so many resources to the treatment of a female member. Either way, women miss out. . . .

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